

## **BENEFITS & REMUNERATION**

## **BENEFITS**

**CareerSource Broward (CSBD) offers the following types of group insurance to employees whose positions are scheduled to last over six (6) months, for which it pays all or part of the corresponding premiums:**

- **Medical/Prescription**
- **Basic Life**
- **Long Term Disability**
- **Accidental Death and Dismemberment**

**Employees may purchase the following types of additional/supplemental insurance:**

- **Dental**
- **Vision**
- **Short term Disability**
- **Hospital Confinement and Critical Care**
- **Cancer and Intensive Care**
- **Life Insurance**
- **Legal Services**
- **Pet Insurance**



# Welcome to Workplace benefits

## Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

## Your coverage options



**Life insurance**

Protecting your family's financial future



**Disability insurance**

Coverage if you're temporarily unable to work

## Ready to enroll?

Only you know what's right for you and your family. Which is why you can choose from a range of plans to pick the best fit.

Whatever you pick, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

- 1 Read through this information.
- 2 Choose the benefits you'd like to take.
- 3 Follow your employer's instructions to complete the enrollment process.

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# Life insurance

If something happens to you, life insurance can help your family reduce financial stress.

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. This ensures that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get affordable life insurance protection for a set period of time.

## Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer is an easier and more affordable option than individual life insurance.

## What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

## Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

You will receive these benefits if you meet the conditions listed in the policy.



## Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a smart way to protect his family.

Jorge has a mortgage, and because his wife is helping to take care of her mother, she only works part-time. In addition, his daughter is about to start college.

Jorge looks at how his family would be affected by losing him.

Average funeral cost: **\$9,000**

Average mortgage debt: **\$202,000**

Average cost of college: **\$17,000 - \$44,000**

Average household credit card debt: **\$8,500**

With life insurance, Jorge can make sure that part of these costs are covered if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

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CAREERSOURCE BROWARD

ALL ELIGIBLE EMPLOYEES

2020-104318 (07/22)

Your benefits as of 10/27/2020

Group number: 00474519



## Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
<b>Employee Benefit</b>	Your employer provides Basic Life Coverage for all full time employees in the amount of 100% of your annual salary, to a maximum of \$200,000.	\$10,000 increments to a maximum of \$400,000. See Cost Illustration page for details.
<b>Accidental Death and Dismemberment</b>	Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage.	Employee coverage. Maximum 1 times life amount.
<b>Spouse/Domestic Partner Benefit</b>	N/A	Up to 100% of employee coverage to a max of \$200,000†
<b>Child Benefit</b>	N/A	Your dependent children age 14 days to 26 years. Up to 100% of employee coverage to a max of \$10,000. Subject to state limits.



# Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
<b>Guarantee Issue:</b> The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to \$200,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 \$100,000, 65-69 \$10,000, 70+ \$0. Spouse Less than age 65 \$10,000, 65-69 \$5,000, 70+ \$0. Dependent children \$10,000. An Additional \$100,000 per employee, \$40,000 for a spouse can be obtained with a "No" response to the Health question (on your enrollment form). Evidence of Insurability is required if the elected amount exceeds the Guarantee Issue plus Additional amount. The Additional amount is available for ages Less than age 65
<b>Premiums</b>	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
<b>Portability:</b> Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions, including evidence of insurability	Yes, with age and other restrictions, including evidence of insurability
<b>Conversion:</b> Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
<b>Accelerated Life Benefit:</b> A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes	Yes
<b>Waiver of Premiums:</b> Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
<b>Benefit Reductions:</b> Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75	35% at age 65, 60% at age 70, 75% at age 75

Subject to coverage limits

‡ Spouse/DP coverage terminates at age 70.

## Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Employee	Policy Election Amount	Monthly premiums displayed.								
		Policy Election Cost Per Age Bracket								
		< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$10,000	Preferred	\$0.50	\$0.50	\$0.80	\$1.50	\$2.30	\$3.50	\$5.70	\$8.90	\$15.00
	Standard	\$0.70	\$0.90	\$1.50	\$2.80	\$4.30	\$6.40	\$9.80	\$15.60	\$24.00
\$20,000	Preferred	\$1.00	\$1.00	\$1.60	\$3.00	\$4.60	\$7.00	\$11.40	\$17.80	\$30.00
	Standard	\$1.40	\$1.80	\$3.00	\$5.60	\$8.60	\$12.80	\$19.60	\$31.20	\$48.00
\$30,000	Preferred	\$1.50	\$1.50	\$2.40	\$4.50	\$6.90	\$10.50	\$17.10	\$26.70	\$45.00
	Standard	\$2.10	\$2.70	\$4.50	\$8.40	\$12.90	\$19.20	\$29.40	\$46.80	\$72.00
\$40,000	Preferred	\$2.00	\$2.00	\$3.20	\$6.00	\$9.20	\$14.00	\$22.80	\$35.60	\$60.00
	Standard	\$2.80	\$3.60	\$6.00	\$11.20	\$17.20	\$25.60	\$39.20	\$62.40	\$96.00
\$50,000	Preferred	\$2.50	\$2.50	\$4.00	\$7.50	\$11.50	\$17.50	\$28.50	\$44.50	\$75.00
	Standard	\$3.50	\$4.50	\$7.50	\$14.00	\$21.50	\$32.00	\$49.00	\$78.00	\$120.00
\$60,000	Preferred	\$3.00	\$3.00	\$4.80	\$9.00	\$13.80	\$21.00	\$34.20	\$53.40	\$90.00
	Standard	\$4.20	\$5.40	\$9.00	\$16.80	\$25.80	\$38.40	\$58.80	\$93.60	\$144.00
\$70,000	Preferred	\$3.50	\$3.50	\$5.60	\$10.50	\$16.10	\$24.50	\$39.90	\$62.30	\$105.00
	Standard	\$4.90	\$6.30	\$10.50	\$19.60	\$30.10	\$44.80	\$68.60	\$109.20	\$168.00
\$80,000	Preferred	\$4.00	\$4.00	\$6.40	\$12.00	\$18.40	\$28.00	\$45.60	\$71.20	\$120.00
	Standard	\$5.60	\$7.20	\$12.00	\$22.40	\$34.40	\$51.20	\$78.40	\$124.80	\$192.00
\$90,000	Preferred	\$4.50	\$4.50	\$7.20	\$13.50	\$20.70	\$31.50	\$51.30	\$80.10	\$135.00
	Standard	\$6.30	\$8.10	\$13.50	\$25.20	\$38.70	\$57.60	\$88.20	\$140.40	\$216.00
\$100,000	Preferred	\$5.00	\$5.00	\$8.00	\$15.00	\$23.00	\$35.00	\$57.00	\$89.00	\$150.00
	Standard	\$7.00	\$9.00	\$15.00	\$28.00	\$43.00	\$64.00	\$98.00	\$156.00	\$240.00
\$110,000	Preferred	\$5.50	\$5.50	\$8.80	\$16.50	\$25.30	\$38.50	\$62.70	\$97.90	\$165.00
	Standard	\$7.70	\$9.90	\$16.50	\$30.80	\$47.30	\$70.40	\$107.80	\$171.60	\$264.00
\$120,000	Preferred	\$6.00	\$6.00	\$9.60	\$18.00	\$27.60	\$42.00	\$68.40	\$106.80	\$180.00
	Standard	\$8.40	\$10.80	\$18.00	\$33.60	\$51.60	\$76.80	\$117.60	\$187.20	\$288.00
\$130,000	Preferred	\$6.50	\$6.50	\$10.40	\$19.50	\$29.90	\$45.50	\$74.10	\$115.70	\$195.00
	Standard	\$9.10	\$11.70	\$19.50	\$36.40	\$55.90	\$83.20	\$127.40	\$202.80	\$312.00
\$140,000	Preferred	\$7.00	\$7.00	\$11.20	\$21.00	\$32.20	\$49.00	\$79.80	\$124.60	\$210.00
	Standard	\$9.80	\$12.60	\$21.00	\$39.20	\$60.20	\$89.60	\$137.20	\$218.40	\$336.00
\$150,000	Preferred	\$7.50	\$7.50	\$12.00	\$22.50	\$34.50	\$52.50	\$85.50	\$133.50	\$225.00
	Standard	\$10.50	\$13.50	\$22.50	\$42.00	\$64.50	\$96.00	\$147.00	\$234.00	\$360.00
\$160,000	Preferred	\$8.00	\$8.00	\$12.80	\$24.00	\$36.80	\$56.00	\$91.20	\$142.40	\$240.00
	Standard	\$11.20	\$14.40	\$24.00	\$44.80	\$68.80	\$102.40	\$156.80	\$249.60	\$384.00
\$170,000	Preferred	\$8.50	\$8.50	\$13.60	\$25.50	\$39.10	\$59.50	\$96.90	\$151.30	\$255.00
	Standard	\$11.90	\$15.30	\$25.50	\$47.60	\$73.10	\$108.80	\$166.60	\$265.20	\$408.00
\$180,000	Preferred	\$9.00	\$9.00	\$14.40	\$27.00	\$41.40	\$63.00	\$102.60	\$160.20	\$270.00
	Standard	\$12.60	\$16.20	\$27.00	\$50.40	\$77.40	\$115.20	\$176.40	\$280.80	\$432.00
\$190,000	Preferred	\$9.50	\$9.50	\$15.20	\$28.50	\$43.70	\$66.50	\$108.30	\$169.10	\$285.00
	Standard	\$13.30	\$17.10	\$28.50	\$53.20	\$81.70	\$121.60	\$186.20	\$296.40	\$456.00
\$200,000	Preferred	\$10.00	\$10.00	\$16.00	\$30.00	\$46.00	\$70.00	\$114.00	\$178.00	\$300.00
	Standard	\$14.00	\$18.00	\$30.00	\$56.00	\$86.00	\$128.00	\$196.00	\$312.00	\$480.00
\$210,000	Preferred	\$10.50	\$10.50	\$16.80	\$31.50	\$48.30	\$73.50	\$119.70	\$186.90	\$315.00
	Standard	\$14.70	\$18.90	\$31.50	\$58.80	\$90.30	\$134.40	\$205.80	\$327.60	\$504.00

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CAREERSOURCE BROWARD  
ALL ELIGIBLE EMPLOYEES

Your benefits as of 10/27/2020  
Group number: 00474519



**Voluntary Life Cost Illustration** *continued*

		< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$220,000	Preferred	\$11.00	\$11.00	\$17.60	\$33.00	\$50.60	\$77.00	\$125.40	\$195.80	\$330.00
	Standard	\$15.40	\$19.80	\$33.00	\$61.60	\$94.60	\$140.80	\$215.60	\$343.20	\$528.00
\$230,000	Preferred	\$11.50	\$11.50	\$18.40	\$34.50	\$52.90	\$80.50	\$131.10	\$204.70	\$345.00
	Standard	\$16.10	\$20.70	\$34.50	\$64.40	\$98.90	\$147.20	\$225.40	\$358.80	\$552.00
\$240,000	Preferred	\$12.00	\$12.00	\$19.20	\$36.00	\$55.20	\$84.00	\$136.80	\$213.60	\$360.00
	Standard	\$16.80	\$21.60	\$36.00	\$67.20	\$103.20	\$153.60	\$235.20	\$374.40	\$576.00
\$250,000	Preferred	\$12.50	\$12.50	\$20.00	\$37.50	\$57.50	\$87.50	\$142.50	\$222.50	\$375.00
	Standard	\$17.50	\$22.50	\$37.50	\$70.00	\$107.50	\$160.00	\$245.00	\$390.00	\$600.00
\$260,000	Preferred	\$13.00	\$13.00	\$20.80	\$39.00	\$59.80	\$91.00	\$148.20	\$231.40	\$390.00
	Standard	\$18.20	\$23.40	\$39.00	\$72.80	\$111.80	\$166.40	\$254.80	\$405.60	\$624.00
\$270,000	Preferred	\$13.50	\$13.50	\$21.60	\$40.50	\$62.10	\$94.50	\$153.90	\$240.30	\$405.00
	Standard	\$18.90	\$24.30	\$40.50	\$75.60	\$116.10	\$172.80	\$264.60	\$421.20	\$648.00
\$280,000	Preferred	\$14.00	\$14.00	\$22.40	\$42.00	\$64.40	\$98.00	\$159.60	\$249.20	\$420.00
	Standard	\$19.60	\$25.20	\$42.00	\$78.40	\$120.40	\$179.20	\$274.40	\$436.80	\$672.00
\$290,000	Preferred	\$14.50	\$14.50	\$23.20	\$43.50	\$66.70	\$101.50	\$165.30	\$258.10	\$435.00
	Standard	\$20.30	\$26.10	\$43.50	\$81.20	\$124.70	\$185.60	\$284.20	\$452.40	\$696.00
\$300,000	Preferred	\$15.00	\$15.00	\$24.00	\$45.00	\$69.00	\$105.00	\$171.00	\$267.00	\$450.00
	Standard	\$21.00	\$27.00	\$45.00	\$84.00	\$129.00	\$192.00	\$294.00	\$468.00	\$720.00
\$310,000	Preferred	\$15.50	\$15.50	\$24.80	\$46.50	\$71.30	\$108.50	\$176.70	\$275.90	\$465.00
	Standard	\$21.70	\$27.90	\$46.50	\$86.80	\$133.30	\$198.40	\$303.80	\$483.60	\$744.00
\$320,000	Preferred	\$16.00	\$16.00	\$25.60	\$48.00	\$73.60	\$112.00	\$182.40	\$284.80	\$480.00
	Standard	\$22.40	\$28.80	\$48.00	\$89.60	\$137.60	\$204.80	\$313.60	\$499.20	\$768.00
\$330,000	Preferred	\$16.50	\$16.50	\$26.40	\$49.50	\$75.90	\$115.50	\$188.10	\$293.70	\$495.00
	Standard	\$23.10	\$29.70	\$49.50	\$92.40	\$141.90	\$211.20	\$323.40	\$514.80	\$792.00
\$340,000	Preferred	\$17.00	\$17.00	\$27.20	\$51.00	\$78.20	\$119.00	\$193.80	\$302.60	\$510.00
	Standard	\$23.80	\$30.60	\$51.00	\$95.20	\$146.20	\$217.60	\$333.20	\$530.40	\$816.00
\$350,000	Preferred	\$17.50	\$17.50	\$28.00	\$52.50	\$80.50	\$122.50	\$199.50	\$311.50	\$525.00
	Standard	\$24.50	\$31.50	\$52.50	\$98.00	\$150.50	\$224.00	\$343.00	\$546.00	\$840.00
\$360,000	Preferred	\$18.00	\$18.00	\$28.80	\$54.00	\$82.80	\$126.00	\$205.20	\$320.40	\$540.00
	Standard	\$25.20	\$32.40	\$54.00	\$100.80	\$154.80	\$230.40	\$352.80	\$561.60	\$864.00
\$370,000	Preferred	\$18.50	\$18.50	\$29.60	\$55.50	\$85.10	\$129.50	\$210.90	\$329.30	\$555.00
	Standard	\$25.90	\$33.30	\$55.50	\$103.60	\$159.10	\$236.80	\$362.60	\$577.20	\$888.00
\$380,000	Preferred	\$19.00	\$19.00	\$30.40	\$57.00	\$87.40	\$133.00	\$216.60	\$338.20	\$570.00
	Standard	\$26.60	\$34.20	\$57.00	\$106.40	\$163.40	\$243.20	\$372.40	\$592.80	\$912.00
\$390,000	Preferred	\$19.50	\$19.50	\$31.20	\$58.50	\$89.70	\$136.50	\$222.30	\$347.10	\$585.00
	Standard	\$27.30	\$35.10	\$58.50	\$109.20	\$167.70	\$249.60	\$382.20	\$608.40	\$936.00
\$400,000	Preferred	\$20.00	\$20.00	\$32.00	\$60.00	\$92.00	\$140.00	\$228.00	\$356.00	\$600.00
	Standard	\$28.00	\$36.00	\$60.00	\$112.00	\$172.00	\$256.00	\$392.00	\$624.00	\$960.00

**Policy Election Amount Up to 100% of Employee Amount to a maximum \$200,000**

Spouse/DP										
\$10,000	Preferred	\$5.00	\$5.00	\$8.00	\$15.00	\$23.00	\$35.00	\$57.00	\$89.00	\$150.00
	Standard	\$7.00	\$9.00	\$15.00	\$28.00	\$43.00	\$66.00	\$105.00	\$165.00	\$270.00
\$20,000	Preferred	\$1.00	\$1.00	\$1.60	\$3.00	\$4.60	\$7.00	\$11.40	\$17.80	\$30.00
	Standard	\$1.40	\$1.80	\$3.00	\$5.60	\$8.60	\$12.80	\$19.60	\$31.20	\$48.00
\$30,000	Preferred	\$1.50	\$1.50	\$2.40	\$4.50	\$6.90	\$10.50	\$17.10	\$26.70	\$45.00
	Standard	\$2.10	\$2.70	\$4.50	\$8.40	\$12.90	\$19.20	\$29.40	\$46.80	\$72.00

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**CAREERSOURCE BROWARD**  
ALL ELIGIBLE EMPLOYEES

Your benefits as of 10/27/2020  
Group number: 00474519

**Voluntary Life Cost Illustration** *continued*

		< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$40,000	Preferred	\$2.00	\$2.00	\$3.20	\$6.00	\$9.20	\$14.00	\$22.80	\$35.60	\$60.00
	Standard	\$2.80	\$3.60	\$6.00	\$11.20	\$17.20	\$25.60	\$39.20	\$62.40	\$96.00
\$50,000	Preferred	\$2.50	\$2.50	\$4.00	\$7.50	\$11.50	\$17.50	\$28.50	\$44.50	\$75.00
	Standard	\$3.50	\$4.50	\$7.50	\$14.00	\$21.50	\$32.00	\$49.00	\$78.00	\$120.00
\$60,000	Preferred	\$3.00	\$3.00	\$4.80	\$9.00	\$13.80	\$21.00	\$34.20	\$53.40	\$90.00
	Standard	\$4.20	\$5.40	\$9.00	\$16.80	\$25.80	\$38.40	\$58.80	\$93.60	\$144.00
\$70,000	Preferred	\$3.50	\$3.50	\$5.60	\$10.50	\$16.10	\$24.50	\$39.90	\$62.30	\$105.00
	Standard	\$4.90	\$6.30	\$10.50	\$19.60	\$30.10	\$44.80	\$68.60	\$109.20	\$168.00
\$80,000	Preferred	\$4.00	\$4.00	\$6.40	\$12.00	\$18.40	\$28.00	\$45.60	\$71.20	\$120.00
	Standard	\$5.60	\$7.20	\$12.00	\$22.40	\$34.40	\$51.20	\$78.40	\$124.80	\$192.00
\$90,000	Preferred	\$4.50	\$4.50	\$7.20	\$13.50	\$20.70	\$31.50	\$51.30	\$80.10	\$135.00
	Standard	\$6.30	\$8.10	\$13.50	\$25.20	\$38.70	\$57.60	\$88.20	\$140.40	\$216.00
\$100,000	Preferred	\$5.00	\$5.00	\$8.00	\$15.00	\$23.00	\$35.00	\$57.00	\$89.00	\$150.00
	Standard	\$7.00	\$9.00	\$15.00	\$28.00	\$43.00	\$64.00	\$98.00	\$156.00	\$240.00
\$110,000	Preferred	\$5.50	\$5.50	\$8.80	\$16.50	\$25.30	\$38.50	\$62.70	\$97.90	\$165.00
	Standard	\$7.70	\$9.90	\$16.50	\$30.80	\$47.30	\$70.40	\$107.80	\$171.60	\$264.00
\$120,000	Preferred	\$6.00	\$6.00	\$9.60	\$18.00	\$27.60	\$42.00	\$68.40	\$106.80	\$180.00
	Standard	\$8.40	\$10.80	\$18.00	\$33.60	\$51.60	\$76.80	\$117.60	\$187.20	\$288.00
\$130,000	Preferred	\$6.50	\$6.50	\$10.40	\$19.50	\$29.90	\$45.50	\$74.10	\$115.70	\$195.00
	Standard	\$9.10	\$11.70	\$19.50	\$36.40	\$55.90	\$83.20	\$127.40	\$202.80	\$312.00
\$140,000	Preferred	\$7.00	\$7.00	\$11.20	\$21.00	\$32.20	\$49.00	\$79.80	\$124.60	\$210.00
	Standard	\$9.80	\$12.60	\$21.00	\$39.20	\$60.20	\$89.60	\$137.20	\$218.40	\$336.00
\$150,000	Preferred	\$7.50	\$7.50	\$12.00	\$22.50	\$34.50	\$52.50	\$85.50	\$133.50	\$225.00
	Standard	\$10.50	\$13.50	\$22.50	\$42.00	\$64.50	\$96.00	\$147.00	\$234.00	\$360.00
\$160,000	Preferred	\$8.00	\$8.00	\$12.80	\$24.00	\$36.80	\$56.00	\$91.20	\$142.40	\$240.00
	Standard	\$11.20	\$14.40	\$24.00	\$44.80	\$68.80	\$102.40	\$156.80	\$249.60	\$384.00
\$170,000	Preferred	\$8.50	\$8.50	\$13.60	\$25.50	\$39.10	\$59.50	\$96.90	\$151.30	\$255.00
	Standard	\$11.90	\$15.30	\$25.50	\$47.60	\$73.10	\$108.80	\$166.60	\$265.20	\$408.00
\$180,000	Preferred	\$9.00	\$9.00	\$14.40	\$27.00	\$41.40	\$63.00	\$102.60	\$160.20	\$270.00
	Standard	\$12.60	\$16.20	\$27.00	\$50.40	\$77.40	\$115.20	\$176.40	\$280.80	\$432.00
\$190,000	Preferred	\$9.50	\$9.50	\$15.20	\$28.50	\$43.70	\$66.50	\$108.30	\$169.10	\$285.00
	Standard	\$13.30	\$17.10	\$28.50	\$53.20	\$81.70	\$121.60	\$186.20	\$296.40	\$456.00
\$200,000	Preferred	\$10.00	\$10.00	\$16.00	\$30.00	\$46.00	\$70.00	\$114.00	\$178.00	\$300.00
	Standard	\$14.00	\$18.00	\$30.00	\$56.00	\$86.00	\$128.00	\$196.00	\$312.00	\$480.00

**Policy Election Amount Up to 100 % of Employee Amount to a maximum of \$10,000**

Child(ren)	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$1,000	\$0.16	\$0.16	\$0.16	\$0.16	\$0.16	\$0.16	\$0.16	\$0.16	\$0.16
\$2,000	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32
\$3,000	\$0.48	\$0.48	\$0.48	\$0.48	\$0.48	\$0.48	\$0.48	\$0.48	\$0.48
\$4,000	\$0.64	\$0.64	\$0.64	\$0.64	\$0.64	\$0.64	\$0.64	\$0.64	\$0.64
\$5,000	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80
\$6,000	\$0.96	\$0.96	\$0.96	\$0.96	\$0.96	\$0.96	\$0.96	\$0.96	\$0.96
\$7,000	\$1.12	\$1.12	\$1.12	\$1.12	\$1.12	\$1.12	\$1.12	\$1.12	\$1.12

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**CAREERSOURCE BROWARD**  
ALL ELIGIBLE EMPLOYEES

Your benefits as of 10/27/2020  
Group number: 00474519

**Voluntary Life Cost Illustration** *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$8,000	\$1.28	\$1.28	\$1.28	\$1.28	\$1.28	\$1.28	\$1.28	\$1.28	\$1.28
\$9,000	\$1.44	\$1.44	\$1.44	\$1.44	\$1.44	\$1.44	\$1.44	\$1.44	\$1.44
\$10,000	\$1.60	\$1.60	\$1.60	\$1.60	\$1.60	\$1.60	\$1.60	\$1.60	\$1.60

Refer to Guarantee Issue row on page above for Voluntary Life GI+AA amounts.

Premiums for Voluntary Life Increase in five-year increments

**Spouse/DP coverage premium is based on Employee age.**

†Benefit reductions apply.

Preferred rates apply to premium for non-tobacco usage and/or health history. Standard rates apply to premium for tobacco usage and/or health history.

**LIMITATIONS AND EXCLUSIONS:**

**A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:**

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

**Voluntary Life Only:**

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-I-R-LB-90, GP-I-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

**For AD&D:** We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-I-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

**Enhanced AD&D:** A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Guardian Group Life Insurance underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.  
Policy Form # GP-1-LIFE-15

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**CAREERSOURCE BROWARD**  
**ALL ELIGIBLE EMPLOYEES**

Your benefits as of 10/27/2020  
Group number: 00474519

## Accidental Death and Dismemberment Life Cost Illustration:

AD&D coverage provides additional benefits following an accidental death or certain bodily injuries. Election amount will equal 1 times the election amount for Voluntary life election.

<b>Employee Policy Election Amount</b>	<b>Monthly Premiums displayed</b>
\$10,000	\$0.25
\$20,000	\$0.50
\$30,000	\$0.75
\$40,000	\$1.00
\$50,000	\$1.25
\$60,000	\$1.50
\$70,000	\$1.75
\$80,000	\$2.00
\$90,000	\$2.25
\$100,000	\$2.50
\$110,000	\$2.75
\$120,000	\$3.00
\$130,000	\$3.25
\$140,000	\$3.50
\$150,000	\$3.75
\$160,000	\$4.00
\$170,000	\$4.25
\$180,000	\$4.50
\$190,000	\$4.75
\$200,000	\$5.00
\$210,000	\$5.25
\$220,000	\$5.50
\$230,000	\$5.75
\$240,000	\$6.00
\$250,000	\$6.25
\$260,000	\$6.50
\$270,000	\$6.75
\$280,000	\$7.00
\$290,000	\$7.25
\$300,000	\$7.50
\$310,000	\$7.75
\$320,000	\$8.00
\$330,000	\$8.25
\$340,000	\$8.50
\$350,000	\$8.75
\$360,000	\$9.00
\$370,000	\$9.25
\$380,000	\$9.50
\$390,000	\$9.75
\$400,000	\$10.00

Benefit reductions apply.

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ALL ELIGIBLE EMPLOYEES**

Your benefits as of 10/27/2020  
Group number: 00474519

## LIMITATIONS AND EXCLUSIONS:

### A SUMMARY OF PLAN LIMITATION AND EXCLUSIONS FOR AD&D

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. This proposal is hedged subject to satisfactory financial evaluation. Please refer to policy booklet for full plan description.

We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared

or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated.

The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Guardian Group AD&D Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form # GP-1-ADD-15.

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Your benefits as of  
Group number:

## WillPrep

Protect the ones you love with a range of dedicated services designed to help you provide for your family.

WillPrep Services includes a range of different resources that make it easier for you to prepare a will.

These range from a library of online planning documents to accessing experienced professionals that can help you with the more complicated details.

### How it can help



Access simple documents including wills and power of attorney letters



Speak with consultants to discuss estate planning



Prepare your will with the assistance or support of an attorney



### How to access

To access WillPrep Services, you'll need a few personal details.



**Visit**

[ibhworklife.com](https://ibhworklife.com)



**User ID**

WillPrep



**Password**

GLIC09

For more information or support, you can reach out by phoning **1800 433 6789**.

**This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.**

WillPrep Services are provided by Integrated Behavioral Health, Inc., and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of Will Prep Services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WillPrep Services at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

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# Disability insurance

## Short term disability

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability is more common than you might realize, and people can be unable to work for all sorts of different reasons. In fact, many disabilities are caused by illness, including common conditions like heart disease and arthritis. However, most disabilities aren't covered by workers' compensation.

### Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It ensures that you'll receive a partial income if you're injured or too sick to work.

### What does it cover?

Most disability insurance pays out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

### Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.



## Replacing income

Mike injures his back in a bicycle accident and can't work for 13 weeks.

---

Unpaid time off work: **13 weeks**

Elimination period: **1 week**

After a 1-week elimination period following his accident, Mike's Guardian Short Term Disability policy kicks in and replaces **\$400** of his weekly income for the remaining **12 weeks** of his rehabilitation.

This gives him a total of **\$4,800** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

You will receive these benefits if you meet the conditions listed in the policy.

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CAREERSOURCE BROWARD

ALL ELIGIBLE EMPLOYEES

2020-104316 (03/21)

Your benefits as of 10/27/2020

Group number: 00474519



# Disability insurance

## Long term disability

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability is more common than you might realize, and people can be unable to work for all sorts of different reasons. In fact, many disabilities are caused by illness, including common conditions like heart disease and arthritis. However, most disabilities aren't covered by workers' compensation.

### Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It ensures that you'll receive a partial income if you're injured or too sick to work.

### What does it cover?

Most disability insurance pays out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

### Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.



## Replacing income

Jim suffers a heart attack that leaves him unable to work for two years.

---

Unpaid time off work: **24 months**

Elimination period: **3 months**

After a 3 month elimination period, Jim's Guardian Long Term Disability policy kicks in and replaces **\$4,000** of his monthly income for the remaining **21 months** of his disability or illness.

This gives him a total of **\$84,000** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

You will receive these benefits if you meet the conditions listed in the policy.

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CAREERSOURCE BROWARD

ALL ELIGIBLE EMPLOYEES

2020-104317 (03/21)

Your benefits as of 10/27/2020

Group number: 00474519





# Your disability coverage

	Short-Term Disability	Long-Term Disability
<b>Coverage amount</b>	60% of salary to maximum \$1250/week	60% of salary to maximum \$6000/month
<b>Maximum payment period:</b> Maximum length of time you can receive disability benefits.	9 weeks	Social Security Normal Retirement Age
<b>Accident benefits begin:</b> The length of time you must be disabled before benefits begin.	Day 1	Day 61
<b>Illness benefits begin:</b> The length of time you must be disabled before benefits begin.	Day 8	Day 61
<b>Evidence of Insurability:</b> A health statement requiring you to answer a few medical history questions.	Health Statement may be required	Health Statement may be required
<b>Guarantee Issue:</b> The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue \$1250 in coverage	We Guarantee Issue \$6000 in coverage
<b>Minimum work hours/week:</b> Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines	Planholder Determines
<b>Pre-existing conditions:</b> A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after 2 week limitation	3 months look back; 12 months after exclusion
<b>Premium waived if disabled:</b> Premium will not need to be paid when you are receiving benefits.	Yes	Yes
<b>Survivor benefit:</b> Additional benefit payable to your family if you die while disabled.	No	3 months

## UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Disability (long-term):** For first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
- **Earnings definition:** Your covered salary excludes bonuses and commissions.
- **Special limitations:** Provides a 24-month benefit limit for specific conditions including mental health and substance abuse. Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

### Short-Term Disability Plan Cost Illustration:

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses.

Policy amounts shown based on sample salary amounts only.

Your premium rate	\$0.310	
<hr/>		
\$20,000 Annual Salary \$231 Weekly Benefit	\$7.16	Deduction
<hr/>		
\$30,000 Annual Salary \$346 Weekly Benefit	\$10.73	Deduction
<hr/>		
\$40,000 Annual Salary \$462 Weekly Benefit	\$14.32	Deduction
<hr/>		
\$50,000 Annual Salary \$577 Weekly Benefit	\$17.89	Deduction
<hr/>		
\$60,000 Annual Salary \$692 Weekly Benefit	\$21.45	Deduction
<hr/>		
\$70,000 Annual Salary \$808 Weekly Benefit	\$25.05	Deduction
<hr/>		
\$80,000 Annual Salary \$923 Weekly Benefit	\$28.61	Deduction
<hr/>		
\$90,000 Annual Salary \$1,038 Weekly Benefit	\$32.18	Deduction
<hr/>		
\$100,000 Annual Salary \$1,154 Weekly Benefit	\$35.77	Deduction
<hr/>		
\$110,000 Annual Salary \$1,250 Weekly Benefit	\$38.75	Deduction
<hr/>		
\$120,000 Annual Salary \$1,250 Weekly Benefit	\$38.75	Deduction
<hr/>		
\$130,000 Annual Salary \$1,250 Weekly Benefit	\$38.75	Deduction
<hr/>		

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ALL ELIGIBLE EMPLOYEES**

Your benefits as of 10/27/2020  
Group number: 00474519

## A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is pledged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Long-Term Disability coverage, we pay no benefits for a disability caused or contributed to by a pre-existing condition unless the disability starts after you have been insured under this plan for a specified period of time. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse.
- For Short-Term Disability coverage, benefits for a disability caused or contributed to by a pre-existing condition are limited, unless the disability starts after you have been insured under this plan for a specified period of time. We do not pay short term disability benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.

Guardian's Group Short-Term Disability and Long-Term Disability Insurance are underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage. Policy Form #GP-1-STD07-1.0, et al, GP-1-STD-15, #GP-1-LTD07-1.0, et al, GP-1-LTD-15.

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Your benefits as of 10/27/2020  
Group number: 00474519

# Electronic Evidence of Insurability (EOI)

Our online EOI forms are an easier, quicker alternative to traditional paper forms, helping you get covered when you need to provide additional information.

There are a few situations where you need to answer health questions, enroll for higher amounts of coverage, or request coverage after the initial eligibility period. In all of these situations, our online EOI form keeps things simple.

## Electronic EOI keeps things simple

With Guardian's electronic EOI forms, your data is kept secure at every stage of the process. And with fewer errors than hand-written forms, and faster submission digitally, it's easier than ever to complete it and get covered.

Electronic EOI can be used for\*:

- Basic life
- Voluntary life
- Short term disability
- Long term disability



## How it works

You will receive a letter or email from your employer or Guardian with instructions and a unique link to submit your EOI form online.

First register and create an account on Guardian Anytime. Then simply fill out the form, electronically sign it, and click 'Submit'.

Once we receive the form, we'll contact you with any questions, before notifying you (and your employer if the coverage amount changes).

\*Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts). Electronic EOI is not available in New York and New Hampshire. Electronic EOI is available using most internet browsers.

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2020-109652 (10/22)

# Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experts, as well as access to resources and discounts designed to help you in a variety of different ways.

## How it can help



Consultative services are available to provide direct support and assistance



Work/life assistance that can help you save money and balance commitments



Access legal and financial assistance and resources – including WillPrep Services



## How to access

To access the WorkLifeMatters Employee Assistance Program, you'll need a few personal details.



### Visit

[ibhworklife.com](http://ibhworklife.com)



### User ID

Matters



### Password

wlm70101

For more information or support, you can reach out by phoning **1800 386 7055**. The team is available 24 hours a day, 7 days a week<sup>1</sup>.

**This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.**

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.

<sup>1</sup>Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

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## Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

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### Important information



#### **Notice Informing Individuals about Nondiscrimination and Accessibility Requirements**

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.

Visit <https://www.guardiananytime.com/notice48> to read more.

#### **No Cost Language Services**

Guardian provides language assistance in multiple languages for members who have limited English proficiency.

Visit <https://www.guardiananytime.com/notice46> to read more.

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### Disability insurance



#### **Disability Offset Notice**

Offsets are provisions in your disability coverage that allow the insurer to deduct from your regular benefit other types of income you receive or are eligible to receive from other sources due to your disability.

Visit <https://www.guardiananytime.com/notice51> to read more.

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Guardian Life, P.O. Box 14319,  
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: CAREERSOURCE BROWARD	Group Plan Number: 00474519	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		

Class: \_\_\_\_\_ Division: \_\_\_\_\_ Subtotal Code: \_\_\_\_\_ (Please obtain this from your Employer)

<b>About You:</b> First, MI, Last Name:		Social Security Number _____ - _____ - _____	
Address	City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm-dd-yy): ____ - ____ - ____	
Phone (indicate primary): <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____ <input type="checkbox"/> Mobile (____) ____ - ____			
Email Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of marriage/union: ____ - ____ - ____	
Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		Placement date of adopted child: ____ - ____ - ____	

<b>About Your Job:</b>		Job Title:
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation		Date of full time hire: ____ - ____ - ____
Hours worked per week: _____	Annual Salary: \$ _____	

**About Your Family:** Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name)		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

**Drop Coverage:**

- Drop Employee     Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: \_\_\_\_\_

- Termination of Employment     Retirement

Last Day Worked: \_\_\_\_\_

- Other Event: \_\_\_\_\_

Date of Event: \_\_\_\_\_

**Coverage Being Dropped:**

- Basic Life  
 Voluntary Life     Employee     Spouse     Child(ren)  
 Long Term Disability  
 Short Term Disability

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

- Covered under another insurance plan  
 Other \_\_\_\_\_

(additional information may be required)

**Basic Life Coverage:**

*Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

**Policy Amount**

Employee Only

100% of your annual salary to a maximum of \$200,000

The Guarantee Issue Amount is \$200,000.

**NAME YOUR BENEFICIARIES (primary beneficiaries must total 100%)**

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

**Primary Beneficiaries:**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ %

Date of Birth (mm-dd-yy): \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ %

Date of Birth (mm-dd-yy): \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

(In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Please contact your employer for any record of or changes to your beneficiary information.

Spouse and dependent child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only.  Yes  No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

**Custodian to Minor Beneficiaries:**

Name: \_\_\_\_\_ Social Security Number (or FEIN/TIN # if a corporate entity): \_\_\_\_\_

Date of Birth (mm-dd-yyyy) (if an individual): \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$: \_\_\_\_\_

**Important Notes:**

- You may be required to complete and evidence of insurability form if you are enrolling after any initial eligibility enrollment period.

**LIFE INSURANCE** *continued*

**Voluntary Term Life Coverage:** You must be enrolled to cover your dependents. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Employee

Policy Amount	<i>Check one box only</i>				
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$60,000
<input type="checkbox"/> \$70,000	<input type="checkbox"/> \$80,000	<input type="checkbox"/> \$90,000	<input type="checkbox"/> \$100,000*	<input type="checkbox"/> \$110,000	<input type="checkbox"/> \$120,000
<input type="checkbox"/> \$130,000	<input type="checkbox"/> \$140,000	<input type="checkbox"/> \$150,000	<input type="checkbox"/> \$160,000	<input type="checkbox"/> \$170,000	<input type="checkbox"/> \$180,000
<input type="checkbox"/> \$190,000	<input type="checkbox"/> \$200,000**	<input type="checkbox"/> \$210,000	<input type="checkbox"/> \$220,000	<input type="checkbox"/> \$230,000	<input type="checkbox"/> \$240,000
<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$260,000	<input type="checkbox"/> \$270,000	<input type="checkbox"/> \$280,000	<input type="checkbox"/> \$290,000	<input type="checkbox"/> \$300,000
<input type="checkbox"/> \$310,000	<input type="checkbox"/> \$320,000	<input type="checkbox"/> \$330,000	<input type="checkbox"/> \$340,000	<input type="checkbox"/> \$350,000	<input type="checkbox"/> \$360,000
<input type="checkbox"/> \$370,000	<input type="checkbox"/> \$380,000	<input type="checkbox"/> \$390,000	<input type="checkbox"/> \$400,000		

Guarantee Issue up to: Employee Less than age 65 \$100,000\*, 65-69 \$10,000, 70+ \$0. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected. Additional Amount: per employee \$100,000\*\*. The Additional amount is available for ages Less than age 65. An Evidence of Insurability form must be completed if any amount above the Guarantee Issue Amount plus Additional Amount is elected.

I do not want this coverage

**Add Voluntary Life for Spouse**

100% of employee's amount to maximum \$200,000 \$ \_\_\_\_\_

Guarantee Issue up to: Spouse Less than age 65 \$10,000, 65-69 \$5,000, 70+ \$0. Additional Amount: Spouse \$40,000\*\*. The Additional amount is available for ages Less than age 65

*\*The amount may not be more than 100% of the employee amount for Voluntary Life.*

I do not want this coverage

**Add Voluntary Life for Dependent/Child(ren)**

100% of employee's amount to maximum \$10,000 \$ \_\_\_\_\_

The Guarantee Issue Amount is \$10,000. The Guarantee Issue with Additional Amount is \$10,000.

*\*The amount may not be more than 100% of the employee amount for Voluntary Life.*

I do not want this coverage

**Add Voluntary AD&D**

You must enroll for voluntary term life to be eligible for this coverage. Your elected amount of coverage will be 1 time(s) the coverage elected for voluntary life.

- Employee
- I do not want this coverage

Have you used any form of tobacco in the past 6 months (e.g., pipe, chewing tobacco) and/or have you smoked cigarettes in the past 12 months?

Employee Yes  No

Spouse Yes  No

**Important Notes:**

- You may be required to complete and evidence of insurability form if you are enrolling after any initial eligibility enrollment period.

**LIFE INSURANCE** *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

**Primary Beneficiaries:**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ % \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ % \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Please contact your employer for any record of or changes to your beneficiary information.

Spouse and dependent child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only.  Yes  No  
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

**Custodian to Minor Beneficiaries:**

Name: \_\_\_\_\_ Social Security Number (or FEIN/TIN # if a corporate entity): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm-dd-yyyy) (if an individual): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

**Short-Term Disability (STD) Coverage:**

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you.

*Weekly Benefit*

- 60% of salary to a maximum of \$1,250  
 I do not want this coverage.

**Long-Term Disability (LTD) Coverage:**

The amount of LTD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you.

*Monthly Benefit*

- 60% of salary to a maximum of \$6,000

**Health History**

Complete the following question if you are enrolling for one or more of the following benefits listed below and you are electing an amount above coverage that is Guaranteed Issue: NOTE: Additional information may be required.

Voluntary Life Insurance

In the last 6 months have you or any of your dependents received diagnosis and/or treatment by a licensed medical professional for medical care, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; or any other Chronic Condition? (Being breast cancer free for 2 or more years and any follow-up does not disqualify an applicant.) (A chronic condition is continuous or persistent over an extended period of time. A chronic condition is one that is long-standing, and not easily or quickly resolved.)

Yes, I have.  No, I haven't.  Yes, my spouse has.  No, my spouse hasn't.  Yes, my dependent child(ren) have.  No, my dependent child(ren) haven't.

Have you or any of your dependent tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derives from such infection?

Yes, I have.  No I haven't.  Yes, my spouse has.  No, my spouse hasn't.  Yes, my dependent child(ren) have.  No, my dependent child(ren) haven't.

An Evidence of Insurability Form must be completed for any person with a "Yes" answer to the questions above.

### Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

The laws of New York require the following statement appear: If you are not a resident of New York this statement does not apply to you. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X \_\_\_\_\_

DATE \_\_\_\_\_

# Career Source

# Dental PPO



	In the Network	Out of the Network
<b>Deductible*—Before the plan pays, you'll pay all costs up to:</b>		
Employee/Family	\$50/\$150	\$50/\$150
<b>Coinsurance*—Once the deductible is met, the plan pays:</b>		
Diagnostic and preventive services (deductible waived)	100%	70%
<b>Basic dental services:</b>		
Restorations	80%	60%
Simple extractions	80%	60%
Emergency treatment/general services	80%	60%
Endodontics	80%	60%
Periodontics	80%	60%
Oral surgery	80%	60%
<b>Major dental services:</b>		
Crowns and bridges	50%	40%
Dentures	50%	40%
<b>Annual limits—This is the most the plan will pay in the plan year.</b>	<b>\$1,500</b>	<b>\$1,000</b>
<b>Orthodontic services:</b>		
Child(ren) to age 19	50%	50%
Lifetime ortho maximum	\$1,000	\$1,000

For more information, please read your plan documents. Additional information such as benefit details, plan limitations and exclusions, and the costs of coverage can be found in the Summary of Benefits

# Humana Dental



Broward County Government

<https://our.humana.com/broward-county/>

**Humana.**





## Feel good about choosing a HumanaDental plan

The HumanaDental HS Series dental plan has you covered for any circumstance. Whether you simply need routine dental care or unexpected dental treatment, you know what to expect with HumanaDental.

- No waiting periods
- No claims to file
- No annual maximums

### Use your HumanaDental benefits

After you enroll in a plan and receive your ID card, you can manage your plan information on your personal home page on [Humana.com](https://www.humana.com).

- You have the freedom to select any participating general dentist as your primary care dentist. To select a dental provider from our network, simply visit [Humana.com](https://www.humana.com). Once there, you can also check your benefits, email us and get a new or temporary ID card. If you prefer, contact us at 1-800-342-5209.
- Life without claim forms! With the HumanaDental Prepaid plan you pay your dentist directly, when applicable.
- Your primary dentist will provide all of your routine dental care and you will pay any copayment or discounted charges at the time of service.

## Good health starts with a healthy mouth

### Make dental visits a priority

One of the first lines of defense in overall health is dental care. Regular dental cleanings can help manage problems throughout the body, such as heart disease, diabetes, and stroke. The HumanaDental Prepaid plan enables you to take better care of your teeth, and you'll pay less for your dental care doing so.

### Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

## Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings



## Questions?

Check out [Humana.com](https://www.humana.com)

Call 1-800-233-4013, Monday through  
Friday, 8 a.m. to 6 p.m.  
(TDD: 1-800-325-2025).

For exclusions and limitations, please review the Specialty Benefits Regulatory and Technical Information Guide available at [Disclosure.Humana.com](https://www.humana.com/disclosure).

# HumanaDental Prepaid HS195MB Plan

The HumanaDental Prepaid plans focus on maintaining oral health, prevention and cost-containment. Members may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. HS plans copayments for listed procedures are applicable at either a participating general dentist or a participating specialist dentist.

A primary care dentist (PCD) may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

**Specialists services:** Should members need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. Visit **Humana.com** to find a participating specialist.

## Summary of services

Services marked with a single asterisk (\*) below also require separate payment of laboratory charges, not to exceed \$200. The laboratory charges must be paid to the plan dentist in addition to any applicable copayment for the service.

<b>Appointments</b>		<b>Member pays</b>		
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	\$ 15.00	D0273 X-ray bitewings—three radiographic images (limited to twice in any 12 calendar months) . . . . no charge	
D9430	Office visit (normal hours)	\$ 5.00	D0274 Bitewings—four radiographic images (limited to twice in any 12 calendar months) . . . . . no charge	
D9440	Office visit (after regularly scheduled hours)	\$ 35.00	D0277 X-ray bitewings, vertical—seven to eight radiographic images (limited to twice in any 12 calendar months) . . . . . no charge	
D9986	Missed appointment	\$ 10.00	D0330 Panoramic radiographic image (once per three calendar years) . . . . . no charge	
D9987	Cancelled appointment	\$ 10.00	D0350 Oral/facial photography images . . . . . no charge	
D9999	Emergency visit during regular scheduled hours, by report	\$ 20.00	D0415 Collect microorganisms culture & sensitivity . . . . no charge	
<b>Diagnostic</b>		<b>Member pays</b>		
D0120	Periodic oral examination (limited to twice in any 12 calendar months)	no charge	D0425 Caries susceptibility tests . . . . . no charge	
D0140	Limited/comprehensive/detailed and extensive oral eval	no charge	D0431 Oral cancer screening using a special light source . . . no charge	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	no charge	D0460 Pulp vitality tests (not covered if a root canal is performed) . . . . . no charge	
D0150	Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)	no charge	D0470 Diagnostic casts . . . . . no charge	
D0160	Limited/comprehensive/detailed and extensive oral eval	no charge	D0472 Pathology report—gross examination of lesion . . no charge	
D0170	Re-evaluation—problem focused (not post-operative visit)	no charge	D0473 Pathology report—microscopic examination of lesion . . . . . no charge	
D0180	Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)	\$ 10.00	D0474 Pathology report—microscopic examination of lesion and area . . . . . no charge	
D0210	X-ray intraoral—complete series including bitewings (once per three calendar years)	no charge	<b>Preventive</b>	
D0220	X-ray intraoral—periapical, first radiographic image	no charge	<b>Member pays</b>	
D0230	X-ray intraoral—periapical, each additional radiographic image	no charge	D1110 Prophylaxis—adult, (limited to three in any 12 calendar months, by primary care dentist) . . . . . no charge	
D0240	X-rays intraoral—occlusal radiographic image	no charge	D1111 Additional adult prophylaxis, with and without fluoride (maximum of two additional per year)	\$ 20.00
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	no charge	D1120 Prophylaxis—child (limited to three in any 12 calendar months, by primary care dentist)	no charge
D0270	X-ray bitewing—single radiographic image (limited to twice in any 12 calendar months)	no charge	D1121 Additional child prophylaxis, with or without fluoride (maximum of two additional per year)	\$20.00
D0272	X-ray bitewings—two radiographic images (limited to twice in any 12 calendar months)	no charge	D1206 Topical application of fluoride varnish (for child <16) (limited to twice in any 12 calendar months)	no charge
			D1208 Topical application of fluoride—excluding varnish (limited to twice in any 12 calendar months)	no charge
			D1310 Nutrition counseling for the control of dental disease	no charge

D1320 Tobacco counseling services for the control or prevention of oral disease	no charge
D1330 Oral hygiene instruction	no charge
D1351 Sealant—per tooth (permanent teeth only to age 16)	\$ 10.00
D1510* Space maintainer—fixed, unilateral (through age 14)	\$ 45.00
D1515* Space maintainer—fixed, bilateral (through age 14)	\$ 45.00
D1520* Space maintainer—removable, unilateral (through age 14)	\$ 85.00
D1525* Space maintainer—removable, bilateral (through age 14)	\$ 85.00
D1550 Re-cement or re-bond space maintainer	\$ 10.00
D1555 Removal of fixed space maintainer	\$ 15.00
D1575 Distal shoe space maintainer - fixed - unilateral (through age 14; primary teeth only)	\$ 55.00

**Restorative**

**Member pays**

D2140 Amalgam—one surface, primary or permanent	no charge
D2150 Amalgam—two surfaces, primary or permanent	no charge
D2160 Amalgam—three surfaces, primary or permanent	no charge
D2161 Amalgam—four or more surfaces, primary or permanent	no charge
D2940 Protective restoration	\$ 15.00

**Resin restorative**

(inlays and onlays limited to one per tooth every five years)

**Member pays**

D2330 Resin based composite—one surface, anterior	\$ 35.00
D2331 Resin based composite—two surfaces, anterior	\$ 40.00
D2332 Resin based composite—three surfaces, anterior	\$ 50.00
D2335 Resin based composite—four or more surfaces or involving incisal angle (anterior)	\$ 70.00
D2390 Resin based composite crown, anterior	\$ 70.00
D2391 Resin based composite—one surface, posterior	\$ 60.00
D2392 Resin based composite—two surfaces, posterior	\$ 80.00
D2393 Resin based composite—three surfaces, posterior	\$ 100.00
D2394 Resin based composite—four or more surfaces, posterior	\$ 120.00
D2510* Inlay—metallic, one surface	\$ 95.00
D2520* Inlay—metallic, two surfaces	\$ 105.00
D2530* Inlay—metallic, three or more surfaces	\$ 130.00
D2542* Onlay—metallic, two surfaces	\$ 230.00
D2543* Onlay—metallic, three surfaces	\$ 230.00
D2544* Onlay—metallic, four or more surfaces	\$ 230.00
D2610* Inlay—porcelain/ceramic, one surface	\$ 230.00
D2620* Inlay—porcelain/ceramic, two surfaces	\$ 230.00
D2630* Inlay—porcelain/ceramic, three or more surfaces	\$ 230.00
D2642* Onlay—porcelain/ceramic, two surfaces	\$ 230.00
D2643* Onlay—porcelain/ceramic, three surfaces	\$ 230.00
D2644* Onlay—porcelain/ceramic, four or more surfaces	\$ 230.00
D2650* Inlay—resin based composite, one surface	\$ 230.00
D2651* Inlay—resin based composite, two surfaces	\$ 230.00
D2652* Inlay—resin based composite, three or more surfaces	\$ 230.00
D2662* Onlay—resin based composite, two surfaces	\$ 230.00
D2663* Onlay—resin based composite, three surfaces	\$ 230.00
D2664* Onlay—resin based composite, four or more surfaces	\$ 230.00

**Crown and bridge**

(limited to one per tooth every five years)

**Member pays**

D2710* Crown—resin based composite, indirect	\$ 230.00
D2712* Crown—3/4 resin based composite, indirect	\$ 230.00

D2720* Crown—resin with high noble metal	\$ 230.00
D2721 Crown—resin with predominantly base metal	\$ 230.00
D2722* Crown—resin with noble metal	\$ 230.00
D2740* Crown - porcelain/ceramic	\$ 280.00
D2750* Crown—porcelain fused to high noble metal	\$ 280.00
D2751 Crown—porcelain fused to predominantly base metal	\$ 280.00
D2752* Crown—porcelain fused to noble metal	\$ 280.00
D2780* Crown—3/4 cast high noble metal	\$ 230.00
D2781 Crown—3/4 cast predominantly base metal	\$ 230.00
D2782* Crown—3/4 cast noble metal	\$ 230.00
D2783* Crown—3/4 porcelain/ceramic	\$ 230.00
D2790* Crown—full cast high noble metal	\$ 280.00
D2791 Crown—full cast predominantly base metal	\$ 280.00
D2792* Crown—full cast noble metal	\$ 280.00
D2794* Crown—titanium	\$ 230.00
D2799 Provisional crown	no charge
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$ 15.00
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core	no charge
D2920 Re-cement or re-bond crown	\$ 15.00
D2929 Crown-Prefabricated porcelain/ceramic crown - primary tooth	\$ 75.00
D2930 Prefabricated stainless steel crown—primary tooth	\$ 75.00
D2931 Prefabricated stainless steel crown—permanent tooth	\$ 25.00
D2932 Prefabricated resin crown	\$ 35.00
D2933 Prefabricated stainless steel crown with resin window	\$ 35.00
D2950 Core buildup, including any pins	\$ 45.00
D2951 Pin retention—per tooth, in addition to restoration	\$ 15.00
D2952* Cast post and core in addition to crown	\$ 90.00
D2953* Each additional cast post—same tooth	\$ 90.00
D2954 Prefabricated post and core in addition to crown	\$ 90.00
D2955 Post removal (not in conjunction with endodontic therapy)	\$ 10.00
D2957 Each additional prefabricated post—same tooth, base metal post	\$ 30.00
D2960 Labial veneer (resin laminate)—chairside	\$ 250.00
D2961* Labial veneer (resin laminate)—laboratory	\$ 300.00
D2962* Labial veneer (porcelain laminate)—laboratory	\$ 280.00
D2970 Temporary crown (fractured tooth)	no charge
D2971 Additional procedure—new crown existing partial denture	\$ 50.00
D2980 Crown repair, necessitated by restorative material failure	no charge
D2981 Inlay repair, necessitated by restorative material failure	no charge
D2982 Onlay repair, necessitated by restorative material failure	no charge
D2983 Veneer repair, necessitated by restorative material failure	no charge
D6940 Stress breaker	\$ 110.00
D6950 Precision attachment, separate from prosthesis	\$ 195.00
D6980* Fixed partial denture repair necessitated by restorative material failure	\$ 45.00

**Prosthodontics (fixed)**

(replacement limited to every five years, adjustments once per year)

**Member pays**

D6210* Pontic—cast high noble metal	\$ 280.00
D6211 Pontic—cast predominantly base metal	\$ 280.00

D6212*	Pontic—cast noble metal	\$280.00
D6240*	Pontic—porcelain fused to high noble metal	\$280.00
D6241	Pontic—porcelain fused to predominantly base metal	\$280.00
D6242*	Pontic—porcelain fused to noble metal	\$280.00
D6750*	Retainer crown—porcelain fused to high noble metal	\$280.00
D6751	Retainer crown—porcelain fused to predominantly base metal	\$280.00
D6752*	Retainer crown—porcelain fused to noble metal	\$280.00
D6790*	Retainer crown—full cast high noble metal	\$280.00
D6791	Retainer crown—full cast predominantly base metal	\$280.00
D6792*	Retainer crown—full cast noble metal	\$280.00
D6794*	Retainer crown—titanium	\$245.00
D6930	Re-cement or re-bond fixed partial denture (per unit)	\$ 10.00

**Prosthodontics**

(replacement limited to every five years) **Member pays**

D5110*	Complete denture—maxillary	\$300.00
D5120*	Complete denture—mandibular	\$300.00
D5130*	Immediate denture—maxillary	\$300.00
D5140*	Immediate denture—mandibular	\$300.00
D5211*	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)	\$300.00
D5212*	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)	\$300.00
D5213*	Maxillary partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	\$300.00
D5214*	Mandibular partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	\$300.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$210.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$210.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$330.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$330.00
D5225*	Maxillary partial denture—flexible (including clasps, rests and teeth)	\$365.00
D5226*	Mandibular partial denture—flexible (including clasps, rests and teeth)	\$365.00
D5281*	Removable unilateral partial denture—one piece cast metal (including clasps and teeth)	\$300.00
D5410	Adjust complete denture—maxillary	\$ 30.00
D5411	Adjust complete denture—mandibular	\$ 30.00
D5421	Adjust partial denture—maxillary	\$ 30.00
D5422	Adjust partial denture—mandibular	\$ 30.00
D5660*	Add clasp to existing partial denture—per tooth	\$ 35.00

**Endodontics**

(each procedure limited to once per tooth per life)

**Member pays**

D3110	Pulp cap—direct (excluding final restoration)	\$ 5.00
D3120	Pulp cap—indirect (excluding final restoration)	\$ 5.00
D3220	Therapeutic pulpotomy (excluding final restoration)	\$ 35.00

D3221	Pulpal debridement, primary and permanent teeth (Not to be used when root canal is done on the same day)	\$100.00
D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)	\$ 40.00
D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)	\$ 40.00
D3310	Root canal therapy—anterior tooth (excluding final restoration)	\$100.00
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	\$200.00
D3330	Endodontic therapy, molar tooth (excluding final restorations)	\$250.00
D3331	Treatment of root canal obstruction—non-surgical access	\$ 85.00
D3332	Incomplete endodontic therapy—inoperable or fractured tooth	\$ 96.00
D3333	Internal root repair of perforation defects	\$ 85.00
D3346	Retreatment of previous root canal therapy—anterior	\$180.00
D3347	Retreatment of previous root canal therapy—bicuspid	\$280.00
D3348	Retreatment of previous root canal therapy—molar	\$325.00
D3351	Apexification/recalcification -initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	\$ 70.00
D3352	Apexification/recalcification—interim medication replacement (includes any necessary radiographs)	\$ 70.00
D3353	Apexification/recalcification—final visit (includes any necessary radiographs)	\$ 70.00
D3410	Apicoectomy—anterior	\$125.00
D3421	Apicoectomy—premolar (first root)	\$ 95.00
D3425	Apicoectomy—molar (first root)	\$ 95.00
D3426	Apicoectomy—(each additional root)	\$ 60.00
D3430	Retrograde filling—per root	\$ 40.00
D3450	Root amputation—per root (not covered in conjunction with procedure D3920)	\$ 95.00
D3910	Surgical procedure to isolate tooth with rubber dam	\$ 19.00
D3920	Hemisection not included in root canal therapy	\$ 90.00
D3950	Canal preparation and fitting of preformed dowel or post	\$ 15.00

**Periodontics (gum treatment)**

**Member pays**

D4210	Gingivectomy/gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant	\$125.00
D4211	Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant	\$ 40.00
D4240	Gingival flap, including root planing—four or more teeth, per quadrant	\$150.00
D4241	Gingival flap, including root planing—one to three teeth, per quadrant	\$113.00
D4245	Apically positioned flap	\$165.00
D4249	Clinical crown lengthening—hard tissue	\$120.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$350.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$350.00
D4263	Bone replacement graft—retained natural tooth—first site in quadrant	\$180.00

D4264	Bone replacement graft—retained natural tooth—each additional site in quadrant	\$ 95.00
D4265	Biological materials which can aid soft and osseous tissue regeneration	\$ 95.00
D4266	Guided tissue regeneration—resorbable barrier, per site	\$215.00
D4267	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)	\$255.00
D4270	Pedicle soft tissue graft procedure	\$245.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$245.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	\$ 75.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$ 70.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$380.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	\$225.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in graft site	\$110.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) — each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$ 75.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) — each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$380.00
D4320	Provisional splinting—intracoronal	\$ 95.00
D4321	Provisional splinting—extracoronal	\$ 85.00
D4341	Periodontal scaling and root planing—four or more teeth per quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months)	\$ 50.00
D4342	Periodontal scaling and root planing one to three teeth per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342)	\$ 50.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation (this service will reduce the number of cleanings available under D1110 and/or D1120)	\$ 50.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (once per five years)	\$ 45.00
D4381	Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three tooth sites per quadrant, and performed no less than three months following active periodontal therapy)	\$ 45.00
D4910	Periodontal maintenance (covered only after active periodontal therapy)	\$ 50.00

D4911	Additional periodontal maintenance procedures (beyond two per 12 months)	\$ 55.00
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**Extractions/oral and maxillofacial surgery Member pays**

D7111	Extraction, coronal remnants — primary tooth	no charge
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	no charge
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$ 40.00
D7220	Removal of impacted tooth—soft tissue	\$ 50.00
D7230	Removal of impacted tooth—partially bony	\$ 70.00
D7240	Removal of impacted tooth—completely bony	\$ 85.00
D7241	Removal of impacted tooth—completely bony, unusual complications by report	\$100.00
D7250	Surgical removal of residual tooth roots	\$ 35.00
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	\$ 50.00
D7280	Exposure of an unerupted tooth (excluding wisdom teeth)	\$ 85.00
D7282	Mobilization of erupted or malposed tooth to aid eruption	\$ 90.00
D7283	Placement of device to facilitate eruption of impacted tooth	\$ 90.00
D7285	Incisional biopsy of oral tissue—hard (bone, tooth)	no charge
D7286	Incisional biopsy of oral tissue—soft (all others)	no charge
D7287	Exfoliative cytological sample collection	\$ 50.00
D7288	Brush biopsy—transepithelial sample collection	\$ 50.00
D7310	Alveoloplasty in conjunction with extractions—per quadrant	\$ 35.00
D7311	Alveoloplasty in conjunction with extractions— one to three teeth or tooth spaces, per quadrant	\$ 35.00
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	\$ 70.00
D7321	Alveoloplasty not in conjunction with extractions —one to three teeth or tooth spaces, per quadrant	\$ 70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	\$ 80.00
D7472	Removal of torus palatinus	\$ 60.00
D7473	Removal of torus mandibularis	\$ 60.00
D7485	Reduction of osseous tuberosity	\$ 60.00
D7510	Incision and drainage of abscess— intraoral soft tissue	\$ 25.00
D7511	Incision and drainage of abscess— intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	\$ 35.00
D7520	Incision and drainage of abscess—extraoral soft tissue	\$ 35.00
D7521	Incision and drainage of abscess—extraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	\$ 35.00
D7910	Suture of recent small wounds up to 5 cm	\$ 25.00
D7960	Frenulectomy (frenectomy or frenotomy)— separate procedure	\$ 50.00
D7963	Frenuloplasty	\$ 50.00
D7970	Excision hyperplastic tissue—per arch	\$ 55.00
D7971	Excision of pericoronal gingiva	\$ 40.00

**Repairs to prosthetics Member pays**

D5511*	Repair broken complete denture base, mandibular	\$ 15.00
D5512*	Repair broken complete denture base, maxillary	\$ 15.00
D5520*	Replace missing or broken teeth—complete denture (each tooth)	\$ 15.00

D5611*	Repair resin partial denture base, mandibular	\$ 15.00
D5612*	Repair resin partial denture base, maxillary	\$ 15.00
D5621*	Repair cast partial framework, mandibular	\$ 30.00
D5622*	Repair cast partial framework, maxillary	\$ 30.00
D5630*	Repair or replace broken clasp—per tooth	\$ 15.00
D5640*	Replace broken teeth—per tooth	\$ 15.00
D5650*	Add tooth to existing partial denture	\$ 30.00
D5670*	Replace all teeth and acrylic on cast metal framework—maxillary	\$165.00
D5671*	Replace all teeth and acrylic on cast metal framework—mandibular	\$165.00
D5710*	Rebase complete maxillary denture	\$ 75.00
D5711*	Rebase complete mandibular denture	\$ 75.00
D5720*	Rebase maxillary partial denture	\$ 75.00
D5721*	Rebase mandibular partial denture	\$ 75.00
D5730	Reline complete maxillary denture (chairside)	\$ 50.00
D5731	Reline complete mandibular denture (chairside)	\$ 50.00
D5740	Reline maxillary partial denture (chairside)	\$ 50.00
D5741	Reline mandibular partial denture (chairside)	\$ 50.00
D5750*	Reline complete maxillary denture (laboratory)	\$ 35.00
D5751*	Reline complete mandibular denture (laboratory)	\$ 35.00
D5760*	Reline maxillary partial denture (laboratory)	\$ 35.00
D5761*	Reline mandibular partial denture (laboratory)	\$ 85.00
D5810*	Interim complete denture (maxillary)	\$230.00
D5811*	Interim complete denture (mandibular)	\$230.00
D5820*	Interim partial denture (maxillary)	\$ 60.00
D5821*	Interim partial denture (mandibular)	\$ 60.00
D5850	Tissue conditioning, maxillary	\$ 30.00
D5851	Tissue conditioning, mandibular	\$ 30.00
D5862*	Precision attachment, by report	\$160.00
D6214*	Pontic titanium	\$230.00
D6245*	Pontic—porcelain/ceramic	\$230.00
D6250*	Pontic—resin with high noble metal	\$230.00
D6251	Pontic—resin with predominantly base metal	\$230.00
D6252*	Pontic—resin with noble metal	\$230.00
D6253*	Provisional pontic	no charge
D6545*	Retainer—cast metal, resin bonded fixed prosthesis	\$200.00
D6549	Resin retainer— for resin bonded fixed prosthesis	\$200.00
D6600*	Retainer inlay—porcelain/ceramic, two surfaces	\$230.00
D6601*	Retainer inlay—porcelain/ceramic, three or more surfaces	\$230.00
D6602*	Retainer inlay—cast high noble metal, two surfaces	\$230.00
D6603*	Retainer inlay—cast high noble metal, three or more surfaces	\$230.00
D6604	Retainer inlay—cast predominantly base metal, two surfaces	\$230.00
D6605	Retainer inlay—cast predominantly base metal, three or more surfaces	\$230.00
D6606*	Retainer inlay—cast noble metal, two surfaces	\$230.00
D6607*	Retainer inlay—cast noble metal, three or more surfaces	\$230.00
D6608*	Retainer onlay—porcelain/ceramic, two surfaces	\$230.00
D6609*	Retainer onlay—porcelain/ceramic, three or more surfaces	\$230.00
D6610*	Retainer onlay—cast high noble metal, two surfaces	\$230.00
D6611*	Retainer onlay—cast high noble metal, three or more surfaces	\$230.00
D6612	Retainer onlay—cast predominantly base metal, two surfaces	\$230.00

D6613	Retainer onlay—cast predominantly base metal, three or more surfaces	\$230.00
D6614*	Retainer onlay—cast noble metal, two surfaces	\$230.00
D6615*	Retainer onlay—cast noble metal, three or more surfaces	\$230.00
D6710*	Retainer crown—indirect resin based composition	\$230.00
D6720*	Retainer crown—resin with high noble metal	\$230.00
D6721	Retainer crown—resin with predominantly base metal	\$230.00
D6722*	Retainer crown—resin with noble metal	\$230.00
D6740*	Retainer crown—porcelain/ceramic	\$230.00
D6780*	Retainer crown—3/4 cast high noble metal	\$230.00
D6781	Retainer crown—3/4 cast predominantly base metal	\$230.00
D6782*	Retainer crown—3/4 cast noble metal	\$230.00
D6783*	Retainer crown—3/4 porcelain/ceramic, denture	\$230.00

### Adjunctive general service

### Member pays

D9110	Palliative (emergency) treatment of dental pain—minor procedure	\$ 10.00
D9120	Fixed partial denture sectioning	no charge
D9210	Local anesthesia not in conjunction with operative or surgical procedures	no charge
D9211	Regional block anesthesia	no charge
D9212	Trigeminal division block anesthesia	no charge
D9215	Local anesthesia in conjunction with operative or surgical procedures	no charge
D9222	Deep sedation/general anesthesia—first 15 minutes	\$ 75.00
D9223	Deep sedation/general anesthesia—each subsequent 15 minute increment	\$ 64.00
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$ 15.00
D9239	Intravenous moderate (conscious) sedation/analgesia—first 15 minutes	\$ 75.00
D9243	Intravenous moderate (conscious) sedation/analgesia—each subsequent 15 minute increment	\$ 64.00
D9248	Non-intravenous conscious sedation	\$ 15.00
D9450	Case presentation, detailed and extensive treatment planning	no charge
D9610	Non-intravenous conscious sedation	\$ 15.00
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	\$ 25.00
D9630	Other drugs and/or medicaments, by report	\$ 15.00
D9910	Application of desensitizing medicament	\$ 15.00
D9940	Occlusal guard, by report	\$ 85.00
D9942	Repair and/or reline of occlusal guard	\$ 40.00
D9951	Occlusal adjustment—limited	\$ 25.00
D9952	Occlusal adjustment—complete	\$150.00

### Bleaching

### Member pays

D9972	External bleaching in office—per arch	\$125.00
D9975	External bleaching in home—per arch	\$125.00

### Orthodontics

### Member pays

D8070	Comprehensive orthodontic treatment of the transitional dentition	\$1,800.00
	Consultation	no charge
	Evaluation	\$ 35.00
	Records/treatment planning	\$ 250.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1,800.00
	Consultation	no charge
	Evaluation	\$ 35.00
	Records/treatment planning	\$ 250.00

D8090	Comprehensive orthodontic treatment of the adult dentition.....	\$ 2,000.00
D8680	Orthodontic retention .....	\$ 450.00
D8693	Re-cement or re-bond fixed retainer .....	no charge

NOTE:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
- Unlisted procedures may be eligible for up to a 25% discount. Members may contact their participating provider to determine if any discounts apply.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional \$75 per unit.
- Some covered services are typically only offered by a specialist (like many oral surgery procedures)
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits. If you do not have a certificate of benefits, please review the Specialty Benefits Regulatory and Technical Information Guide available at [Disclosure.Humana.com](http://Disclosure.Humana.com).

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Offered by CompBenefits Company.



[Humana.com](http://Humana.com)



# Schedule of benefits

Florida: HS195MB

## Implants Services:

Implants and implant supported prostheses are covered with a 50% copayment up to an annual maximum benefit of \$1,500 and a \$10,000 lifetime maximum benefit. The Member is responsible for payment of the copayment and any amounts in excess of the annual maximum benefit. No benefits for implants and implant supported prostheses are available after the lifetime maximum is met.

Implants and implant supported prostheses covered under this plan are limited to the replacement of permanent teeth extracted while covered under this plan, or for replacement of a prior prosthesis if it has been at least five years since the prior insertion, and is not, and cannot be made serviceable.

### NOTE:

1. Not all Participating Dentists perform all listed procedures, including amalgams. Please consult Your dentist prior to treatment for availability of services.
2. Some Covered Dental Care Services are typically only offered by a specialist (like many oral surgery procedures).
3. When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional \$75 per unit.
4. Additional exclusions and limitations are listed along with full plan information in your Certificate of Dental Benefits.
5. Copayment amounts for listed procedures are applicable at either the Participating General Dentist or Participating Specialist. Specialist services are only available in areas where the dental plan has a Participating Specialist.



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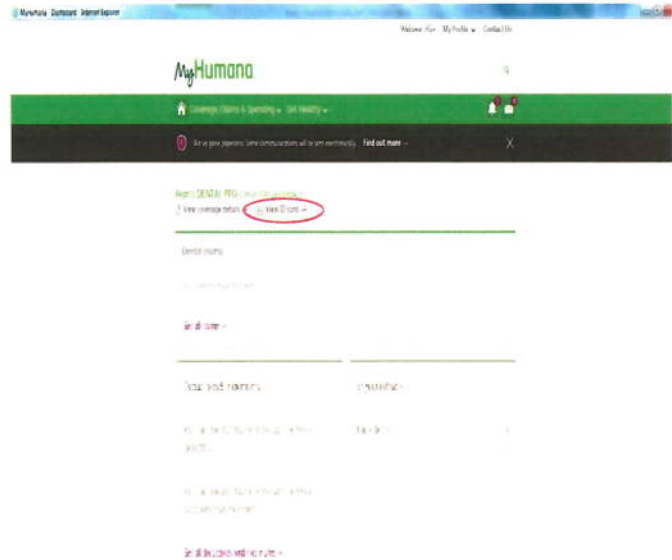


# How to view a copy of your dental identification (ID) card

You will have access to view and print your dental ID cards via the website or mobile app within 10 working days of enrollment.

## Here's how

- Go to **Humana.com** and sign in/register for MyHumana (Have your Humana member ID or Social Security number available)
- Click "Access your ID Card" under "Tools & forms" in the lower right of your MyHumana home page or in the page's footer under "Tools & Resources"
- A new window will appear with links to the ID card or proof of coverage
- Print if desired.



Call Customer Care at **1-866-4ASSIST**  
**(1-866-427-7478)** for assistance or  
more information

**Humana.**

Humana.com

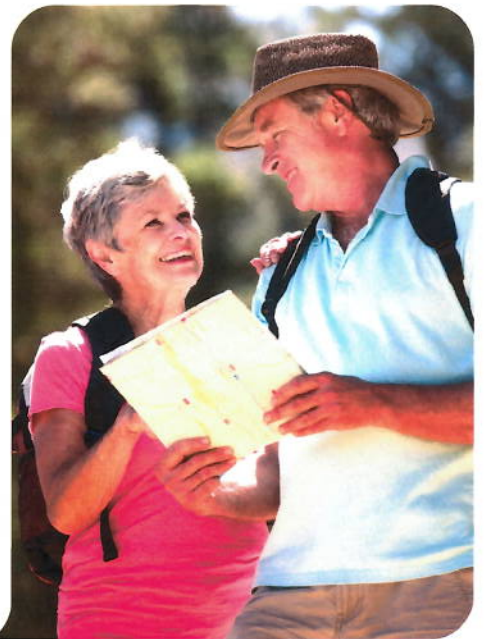
## Pre-Determination of Your HumanaDental Benefits

- If you expect to pay more than \$300 for dental care, your dentist may submit a proposed dental treatment plan that Humana will use to determine if your dental benefits cover the treatment.
- This is known as a “predetermination of benefits” (also called “prior authorization”)
- The dental treatment plan may include:
  - A list of services to be performed, including any supporting documentation
  - A written description from the dentist of the treatment
  - An itemized list of costs
- **Please note:** With limited exceptions, predetermination of benefits must be granted before the service is provided. It will remain valid for up to 90 days after the review, and is not a guarantee of what we will pay toward the treatment.



# Humana Lifestyle Discount Program

Helping you achieve lifelong well-being through a balanced sense of purpose, belonging, health and security.



## Your wellness is Humana's business

To make it easier and more affordable to take better care of yourself, Humana offers the Lifestyle Discount Program. This isn't an insurance plan. It's a discount program to strengthen your personal well-being and enrich your life. As a Humana member, you have access to this valuable program.

**Humana.**



Humana's Lifestyle Discount Program can help you look and feel your very best by giving you more choices and savings for health and wellness procedures.

All discounts are available to Humana group members at the time of service — with unlimited usage. Just sign in to **[Humana.com/LifestyleDiscounts](https://www.humana.com/LifestyleDiscounts)**



### Acupuncture and massage therapy

Immediate savings. That's what this discount can mean to you. These holistic approaches provide you a natural option for pain relief. You'll get on-the-spot discounts of up to 30 percent when you receive services from Healthways WholeHealth Network providers.

Choose from:

- Massage therapy
- Acupuncture

It's easy to get your savings from more than 37,000 Healthways WholeHealth Network providers. To get started, sign in to **[Humana.com/LifestyleDiscounts](https://www.humana.com/LifestyleDiscounts)** and select the link to Healthways. If you prefer, call Healthways at **1-800-274-7526**.



**Humana**®



## Weight Loss

A healthy you starts with what you eat. Receive a 12 percent discount on a 28-day meal plan from Nutrisystem® so you can eat right without worry. The Nutrisystem programs are based on 40 years of nutrition research and the science of the low glycemic index. They offer a variety of great tasting, satisfying, good carbohydrate meals designed to be heart healthy.

To get started, sign in to **Humana.com/LifestyleDiscounts** and select the link to Nutrisystem. If you prefer, call Nutrisystem at **1-888-870-2356**.

## Lasik

Experience the benefits of Lasik and see significant savings! With nearly 600 locations nationwide, members may choose any in-network provider and receive these discounts: 15 percent off standard prices or 5 percent off promotional prices. Extra Member Value — Having performed over 1 million procedures nationwide, LasikPlus is the “featured” network provider and offers members:

- Special “set prices”
- Free Lasik exam (save more than \$100)
- Affordable financing options
- Multiple technologies (100 percent bladeless procedures)
- Free enhancements for life on most procedures

To get started, sign in to **Humana.com/LifestyleDiscounts** and select the link to Lasik. If you prefer, call **1-855-645-2020**.

## Teeth Whitening

Smile big and proud with a fresh set of pearly whites. Humana teamed up with ProSmileUSA™ to offer up to 70 percent off teeth whitening. Just go online and order the ProSmileUSA state-of-the-art whitening system. You'll be on your way to glimmering teeth. ProSmileUSA, a division of United Networks of America, is a national dental lab that specializes in Hi-Intensity™, competitive strength, professional teeth bleaching.

To order a teeth whitening kit, sign in to **Humana.com/LifestyleDiscounts** and select the link to ProSmileUSA. If you prefer, call ProSmileUSA at **1-866-944-8330**.

## Identity monitoring and protection services

Protect yourself and your loved ones with identity monitoring and protection services provided by Identity Theft 911. At every stage of life, this benefit provides expert support to help detect fraud, monitor credit activity and resolve any identity-related issues. There are three packages available to Humana members. You can choose the package that fits your budget, all options include:

- Medical identity theft monitoring
- Internet monitoring
- Credit bureau monitoring, including credit score
- Unlimited access to expert fraud specialists for proactive and identity resolution assistance

To get started or to review a complete list of services and savings, sign in to **Humana.com/LifestyleDiscounts** and select the link to Identity Theft 911.

If you prefer, call the phone number on your Humana member ID card or **1-800-4Humana (1-800-448-6262)** to find out more. You don't need a referral. However, some Humana health plans offer coverage for some alternative services. Please review your Certificate of Coverage/Summary Plan Description for specific benefits. The discounts offered are not insurance and are not intended as a substitute for insurance.

# Humana.

### **Discrimination is against the law**

Humana Inc. and its subsidiaries comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-877-320-1235** or if you use a TTY, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Discrimination Grievances  
P.O. Box 14618  
Lexington, KY 40512-4618

If you need help filing a grievance, call **1-877-320-1235**, or if you use a TTY, call **711**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

**1-800-368-1019, 800-537-7697 (TDD)**

Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**



## Multi-Language Interpreter Services

**English: ATTENTION:** If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-320-1235 (TTY: 711)**.

**Español (Spanish): ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235 (TTY: 711)**.

**繁體中文 (Chinese): 注意:** 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 **1-877-320-1235 (TTY: 711)**。

**Tiếng Việt (Vietnamese): CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-320-1235 (TTY: 711)**.

**한국어 (Korean): 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-320-1235 (TTY: 711)**번으로 전화해 주십시오.

**Tagalog (Tagalog – Filipino): PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-320-1235 (TTY: 711)**.

**Русский (Russian): ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-320-1235 (телетайп: 711)**.

**Kreyòl Ayisyen (French Creole): ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-320-1235 (TTY: 711)**.

**Français (French): ATTENTION :** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-320-1235 (ATS : 711)**.

**Polski (Polish): UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-320-1235 (TTY: 711)**.

**Português (Portuguese): ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-320-1235 (TTY: 711)**.

**Italiano (Italian): ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-320-1235 (TTY: 711)**.

**Deutsch (German): ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-320-1235 (TTY: 711)**.

**日本語 (Japanese): 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-320-1235 (TTY: 711)** まで、お電話にてご連絡ください。

**فارسی (Farsi):**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-877-320-1235 (TTY: 711)** تماس بگیرید.

**Diné Bizaad (Navajo): Díí baa akó nínizín:** Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiił'eh, éí ná hóló, kójjí' hódíłnih **1-877-320-1235 (TTY: 711)**.

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-320-1235 (رقم هاتف الصم والبكم: 711)**.

**Humana**

Relationships are built on trust. Respect for an individual's privacy goes a long way toward building trust. Humana values our relationship with you, and we take your personal privacy seriously. Humana's Notice of Privacy Practices outlines how Humana may use or disclose your personal and health information. It also tells how we protect this information. The notice provides an explanation of your rights concerning your information, including how you can access this information and how to limit access to your information. In addition, it provides instructions on how to file a privacy complaint with Humana or to exercise any of your rights regarding your information.

If you'd like a copy of Humana's Notice of Privacy Practices, you can request a copy by:

- Visiting [Humana.com](http://Humana.com) and clicking the Privacy Practices link at the bottom of the home page.
- E-mailing us at [privacyoffice@humana.com](mailto:privacyoffice@humana.com)
- Sending a written request to:  
Humana Privacy Office  
P.O. Box 1438  
Louisville, KY 40202



UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

Rates (Bi-Weekly)	Exam with Materials
Employee	\$3.59
Employee + Spouse	\$7.20
Employee + Child(ren)	\$6.82
Employee + Family	\$10.72

Benefit Frequency	
Comprehensive Exam(s)	Once every Calendar Year(s)
Comprehensive Exam(s) for diabetics only	Twice every Calendar Year(s)
Spectacle Lenses	Once every Calendar Year(s)
Frames	Once every Calendar Year(s)
Contact Lenses in Lieu of Eyeglasses	Once every Calendar Year(s)

#### In-Network Services

Copays	
Exam(s)	\$ 10.00
Materials	\$ 15.00
Retinal Screening for Diabetics	\$ 0.00

Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage) <sup>1</sup>	
Private Practice Provider	\$75.00 wholesale allowance (approximate retail value of \$187.50)
Retail Chain Provider	\$225.00 retail frame allowance

Lens Options	
Standard Scratch-resistant Coating, Standard Progressive Lenses, Deluxe Progressive Lenses, Polycarbonate Lenses - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider). The Lens Options list can be found at <a href="http://myuhcvision.com/browardbocc">myuhcvision.com/browardbocc</a> .	

**Contact Lens Benefit<sup>2</sup>** (Selection contact lenses refers to our formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at [myuhcvision.com/browardbocc](http://myuhcvision.com/browardbocc)).

<b>Selection contact lenses</b> The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
<b>Non-selection contact lenses</b> An allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	\$105.00
<b>Necessary contact lenses<sup>3</sup></b>	Covered in full after copay (if applicable).

#### Out-of-Network Reimbursements (Copays do not apply)

Exam(s)	Up to \$40.00
Frames	Up to \$65.00
Single Vision Lenses	Up to \$40.00
Lined Bifocal Lenses	Up to \$60.00
Lined Trifocal Lenses	Up to \$80.00
Lenticular Lenses	Up to \$100.00
Elective Contacts in Lieu of Eyeglasses <sup>2</sup>	Up to \$105.00
Necessary Contacts in Lieu of Eyeglasses <sup>3</sup>	Up to \$210.00

## Discounts

### Laser vision

UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at [www.uhclasik.com](http://www.uhclasik.com).

### Additional Material

At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

### Hearing Aids

As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to [hiHealthInnovations.com](http://hiHealthInnovations.com). When placing your order use promo code myVision to get the special price discount.

## Sample Illustration of Savings

Cost	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Bi-Weekly Premium	\$3.59	\$7.20	\$6.82	\$10.72
Annual Premium	\$93.36	\$187.08	\$177.36	\$278.76
Approx. Pre-Tax Savings (20%) <sup>4</sup>	\$18.67	\$37.42	\$35.47	\$55.75
Annual Tax-Adjusted Premium	\$74.69	\$149.66	\$141.89	\$223.01
Plus Copays	\$25.00	\$50.00	\$75.00	\$100.00
<b>Total Cost to Employee</b>	<b>\$99.69</b>	<b>\$199.66</b>	<b>\$216.89</b>	<b>\$323.01</b>

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan <sup>5</sup>	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Only Exam, Single Vision & Covered-in-Full Frame	\$275.00	\$99.69	\$175.31
Employee + Spouse Exam, Single Vision & Covered-in-Full Frame	\$550.00	\$199.66	\$350.34
Employee + Child(ren) <sup>6</sup> Exam, Single Vision & Covered-in-Full Frame	\$825.00	\$216.89	\$608.11
Employee + Family <sup>7</sup> Exam, Single Vision & Covered-in-Full Frame	\$1,100.00	\$323.01	\$776.99

<sup>1</sup>30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.

<sup>2</sup>Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.

<sup>3</sup>Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

<sup>4</sup>Actual tax savings will depend upon your individual tax bracket.

<sup>5</sup>Approximate retail value illustrated: Exam & Refraction (\$65), Single Vision Lenses (\$80), and Frames (\$130). Average retail cost may vary by provider.

<sup>6</sup>For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

<sup>7</sup>For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

## Important to Remember:

### In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your \$105.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. The Lens Options list can be found at [myuhcvision.com/browardbocc](http://myuhcvision.com/browardbocc).

### Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website [myuhcvision.com/browardbocc](http://myuhcvision.com/browardbocc) or call (855) 819-0928, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at [myuhcvision.com/browardbocc](http://myuhcvision.com/browardbocc). Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

**In-Network Provider** - Copays and non-covered patient options are paid to provider by program participant at the time of service.

**Out-of-Network Provider** - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

**Customer Service is available toll-free at (855) 819-0928 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.**

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

**CAREERSOURCE BROWARD JOB TITLES AND REMUNERATION**

For job titles with multiple incumbents, we have provided the salary ranges.

<b>Pay Grade</b>	<b>CSBD Job Titles</b>	<b>Minimum</b>	<b>Maximum</b>
3	Administrative Assistant	\$36,800	\$55,200
6	Business Services Manager (Intermediaries)	\$48,400	\$75,000
4	Computer Technician	\$40,100	\$60,200
7	Program Manager	\$54,200	\$84,000
12	Vice President (HR, QA, CBR)	\$95,600	\$148,200
9	Sr. QA Analysts	\$68,000	\$105,400
13	Senior Vice President (IT, Operations )	\$107,100	\$166,000

For those job titles where there is only one incumbent, the current salary of the individual is provided below.

<b>Pay Grade</b>	<b>CSBD Job Titles</b>	<b>Current Salary</b>
8	Accountant 2	\$ 70,907.07
4	Accounts Payable Coordinator	\$ 40,500.00
4	Community Liaison	\$ 40,500.00
7	Computer Technician Supervisor	\$ 69,627.87
9	Controller	\$ 85,207.00
7	Executive Secretary	\$ 65,081.45
15	Executive Vice President	\$ 145,003.95
17	General Counsel	\$ 210,582.06
5	Human Resources Assistant	\$ 58,491.23
6	Legal Secretary	\$ 48,400.00
5	Multimedia Design & Marketing Specialist	\$ 50,363.00
8	Network Administrator	\$ 76,578.53
3	Payroll Specialist	\$ 40,069.58
18	President/CEO	\$ 225,000.00
4	Purchasing Coordinator	\$ 41,183.22
7	Quality Assurance Analyst	\$ 65,695.70
6	Sr. Business Services Representative	\$ 58,000.02
9	Sr. Financial Audit & Compliance Analyst (PT)	\$ 66,150.00
10	Sr. Mgr. Career Center Services	\$ 90,297.60
14	Sr. Vice President of Finance	\$ 154,893.96
8	Systems Analyst/Programmer	\$ 75,000.12

**EXHIBIT E**  
**TOTAL COMPENSATION OF EXECUTIVE LEADERSHIP AND OTHER SPECIFIED EMPLOYEES**  
(Subsection 445.007(13), Florida Statutes, and Executive Order 20-44)

Entity Name:

CareerSource Broward

Employee Name	Carol Hylton	Ron Moffett	Rochelle Daniels	Christine Azor	Michael Bateman	Tony Ash
Title	President/CEO	Executive VP	General Counsel	SVP Finance	VP Quality Assurance	VP of CBR
Salary	\$200,000.00	\$129,900.17	\$195,018.37	\$141,248.10	\$107,016.76	\$103,601.34
Bonuses						
Cashed-In Leave	\$3,846.15	\$5,329.23	-	-	-	\$3,625.01
Cash Equivalents						
Cash Equivalents Description						
Severance Pay						
Retirement Benefits (Pension Plan Accruals and Contributions)						
Employer-Paid Insurance Benefits	\$11,704.17	\$10,344.78	\$1,678.59	\$7,813.77	\$7,461.48	\$10,804.29
Deferred Compensation	\$7,774.99	-	\$5,625.25	\$5,625.25	\$5,625.25	\$2,351.98
Real Property Gifts						
Real Property Gifts Description						
Other Payouts	-	-	-	-	-	\$50.00
Other Payouts Description						
Total Compensation	\$223,325.31	\$145,574.18	\$202,322.21	\$154,687.12	\$120,103.49	\$120,432.62
Present Value of Vested Benefits including, but not limited to, Retirement, Accrual Leave and Paid Time Off	\$50,830.77	\$8,403.53	\$33,592.48	\$15,498.03	\$26,992.38	\$13,416.65
Percentage of Total Compensation from Federal or State Funds	89%	93%	94%	89%	100%	100%

Under penalties of perjury, I declare that I have read the foregoing schedule of Total Compensation of Executive Leadership and Other Specified Employees and that the facts stated in it are true.



Signature

Carol Hyatt

Printed Name

President

Title

**Definitions:**

**Executive Leadership:** Chief executive officer/executive director of the board and those reporting directly to that position.

**Cash Equivalents:** Gift cards, vouchers, tickets, or other items of monetary value.

**Other payouts:** Cell phone allowances, tuition, gym memberships, car allowances, etc.

**Employer-Paid Insurance Benefits:** Amount of insurance paid by the employer for health, vision, life, dental, disability, etc. (does not include taxes such as FICA, reemployment, etc.)

**Present Value of Vested Benefits including, but not limited to, Retirement, Accrual Leave and Paid Time Off:** Current discounted value of any vested benefit available to the employee at fiscal year end.